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Bureau of Health Care Quality & Compliance

AND DIAM OF CODDECTION		(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBI	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NVS4138AGZ				B. WING		10/02/2008			
•			STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	•			
SILVERWOOD CARE HOME				BRONCO BUSTER COURT S VEGAS, NV 89032					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
Y 000	Initial Comments			Y 000					
	This Statement of Deficiencies was generated as a result of the annual state licensure survey conducted at your facility on October 2, 2008								
	The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006.								
	Residential Facility fo	sed as a Six (6) beds ir Groups which provide sabled persons, Catego							
	The census at the tim residents.	e census at the time of the survey was 5 idents.							
	There were five (5) rothere (3) employee file	esident files reviewed a es reviewed.	ind						
	by the Health Division prohibiting any crimin actions or other claim	clusions of any investign shall not be construed all or civil investigations for relief that may be under applicable feder	l as s,						
	The following regulate identified:	ory deficiencies were							
Y 103 SS=F	449.200(1)(d) Person	nel File - NAC 441A		Y 103					
	a separate personnel member of the staff o	ee provided in subsection file must be kept for ea of a facility and must inc ates required pursuant for the employee.	ach lude:						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS4138AGZ 10/02/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3527 BRONCO BUSTER COURT SILVERWOOD CARE HOME N LAS VEGAS, NV 89032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 103 Y 103 Continued From page 1 This Regulation is not met as evidenced by: NAC 441A.375 Medical facilities, facilities for the dependent and homes for individual residential care: Management of cases and suspected cases; surveillance and testing of employees; counseling and preventive treatment. 1. A case having tuberculosis or suspected case considered to have tuberculosis in a medical facility or a facility for the dependent must be managed in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the dependent or a home for individual residential care shall maintain surveillance of employees of the facility or home for tuberculosis and tuberculosis infection. The surveillance of employees must be conducted in accordance with the recommendations of the Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities providing health care set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall have a: (a) Physical examination or certification from a licensed physician that the person is in a state of

good health, is free from active tuberculosis and any other communicable disease in a contagious

(b) Tuberculosis screening test within the

stage; and

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employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist,

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(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

10/02/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SILVERWOOD CARE HOME		3527 BRONCO BUSTER COURT N LAS VEGAS, NV 89032				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
Y 103	Continued From page 3 if any, or to the director or other person in choof the medical facility if the medical facility hadesignated an infection control specialist, whany pulmonary symptoms develop. If symptor of tuberculosis are present, the employee shoe evaluated for tuberculosis. Based on record review the facility failed to ensure that 1 of 3 employees had received to required tuberculosis (TB) screening. (#1) Findings include: Employee #1's (date of hire 9-1-08) file did contain documented evidence that the employed completed the required two-step tuberculos screening. The file did include results of one negative PPD tuberculin screening on 8-13-6	narge as not hen oms nall the	Y 103			
	Severity: 2 Scope: 2 449.200(1)(e) Personnel File - References		Y 104			
SS=C	NAC 449.200 1. Except as otherwise provided in subsection a separate personnel file must be kept for earnember of the staff of a facility and must incomplete (e) Evidence that the references supplied by employee were checked by the residential face.	ach clude: / the				
	This Regulation is not met as evidenced by: Based on record review the facility failed to ensure that references supplied by the employees were checked on 2 of 3 employe					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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A. BUILDING

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NVS4138AGZ

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER SILVERWOOD CARE HOME		3527 BRONCO BUSTER COURT N LAS VEGAS, NV 89032					
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Y 104	Continued From page 4 (#2, #3) Findings include: The personnel file of Employee #2 (hire date 9-1-08) only contained one reference check. The personnel file of Employee #3 (hire date 7-28-08) did not contain any reference check. Severity: 1 Scope: 3 449.2744(1)(b)(4) Medication / MAR						
SS=D	NAC 449.2744 1. The administrator of a residential facility the provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered each resident. The record must include: (4) Instructions for administering the medication to the resident that reflect the cur order or prescription of the resident's physicials.	to					
	This Regulation is not met as evidenced by: Based on interview and record review the fa failed to ensure that the medication administ to 1 of 5 residents reflected the current prescription of the resident's physician. (#4) Findings include:	cility					
	The label on the medication bottle and the physician's order for Resident #4's Lisinopril	read					

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